TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Orthopedic & Spine

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-0665-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following claim was not processed according to Texas fee guidelines for inpatient services."

Amount in Dispute: $1,098.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on November 11, 2016. Texas Administrative Code §133.307 (d) (1) states,

> Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
>
> (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As no response was received, this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3 – 5 , 2016	Inpatient Hospital Services	$1,098.78	$1,098.78

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 252 – An attachment /other documentation is required to adjudicate this claim/service
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - W3 – In accordance with TDI-DWC Rule 134.804 this bill has been identified as a request for reconsideration or appeal

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment for inpatient hospital services rendered from February 3 – 5,016. The insurance carrier reduced payment for the disputed services with claim adjustment reason code P12 – "Workers' compensation jurisdictional fee schedule adjustment" and 45 – "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."

   28 Texas Administrative Code §134.404 (f) states in pertinent part,
   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 143 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

   Review of the submitted medical claim finds separate reimbursement was requested for implantables. Therefore the services in dispute will be calculated based on provisions of 134.404(f)(1)(B).

2. Per §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are $12,263.42. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

   The maximum allowable reimbursement will be calculated below to determine if the carrier's reductions are supported.

   Per §134.404(f)(1)(A), the sum of the Medicare facility specific amount, including any outlier payment, is multiplied by 108%. Information regarding the calculation of Medicare IPPS payment rates may be

found at http://www.cms.gov. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 473. The services were provided at Baylor Orthopedic and Spine Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is $12,775.95 - $118.11 (identified as VBP) = $12,657.84.

Note: A claim payment identified as "VBP" on the *Medicare Inpatient PPS Pricer* was subtracted from total DRG amount for this admission. "VBP" stands for Value-Based Purchasing (VBP). Medicare's VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. The fee rule for inpatient hospital services contains a conflict provision which explains that the Texas Labor Code in such instances takes precedence:

> 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

Because the Medicare VBP program conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system, the VPB payment must be subtracted out of the total DRG.

This amount (12,657.84) multiplied by 108% results in a MAR of $13,670.47.

3. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g),

> Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission

Review of the submitted documentation finds that the separate implantables include:

- Screw Solstice 3.5 x 12m quantity 8, charge amount $9,096.00
- Rod Sentinel 3.5 x 80mm quantity 2, charge amount $490.00
- Cap Locking T15 Solstice quantity 8, charge amount $1,256.00
- Graft bone putty 10cc quantity 1, charge amount $1,421.42

The total net invoice amount (exclusive of rebates and discounts) is $12,263.42.

The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,226.34.

The total recommended reimbursement amount for the implantable items is $13,489.76. Therefore, the Division finds the carrier's reduction of payment is not supported.

4. The total recommended payment for the services in dispute is $27,160.23. The insurance carrier has paid $26,061.45. The requestor is seeking $1,098.78. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,098.78.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,098.78, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		December 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.